VERMONT
AGENCY OF HUMAN SERVICES

OFFICE OF VERMONT HEALTH ACCESS

OUT-OF-STATE MEDICAID TRANSPORTATION

PHYSICIAN REFERRAL FORM

The Office of Vermont Health Access (OVHA) provides travel assistance to eligible Medicaid recipients to access necessary medical services. Please provide the following information to help us render that assistance. Thank you.

Physician's Office: Please mail or fax this completed form directly to Peter McNichol, Office of Vermont Health Access, 312 Hurricane Lane, Suite 201, Williston, VT 05495. Fax 879-5919.

Client Name _____

Medicaid Number _____ DOB_____

Appointment Date and Time _____

Name of Primary Physician _____

Physician to whom the patient is being referred

Name _____

Address _____

_____

Phone # _____

Is overnight lodging necessary? Yes _____ No _____

Medically, how many people should accompany the patient? _____

Please answer the following questions that are applicable to the purpose of the travel request. If necessary, use an additional sheet of paper.

If the transportation is requested in order to obtain a particular type of **medical service**:

- What is the precise medical service that will be delivered at the destination?
- Is this service medically necessary? If so, why?
- Is this service obtainable in Vermont? If your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?
- Is this the closest provider that can provide the service?

If the transportation is requested in order to obtain a particular type of **medical expertise:**

- Does the medical provider who the patient will visit possess special expertise with regard to this patient or this patient's medical condition? If so, what is the precise nature of this expertise?
- Is it medically necessary for the patient to be treated by a provider with this special expertise?
- Is such expertise obtainable in Vermont? If your answer is no, what efforts have been made to determine whether it is obtainable in Vermont?
- Is this the closest provider that can provide such expertise?

If the transportation is requested in order to maintain **continuity of care**:

- What is the patient's history with the provider, i.e., duration, condition(s) under treatment, nature of treatment(s)?
- Is it medically necessary for the patient to be treated by this particular provider rather than another similarly qualified provider? If so, why?

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Print name of Doctor or Doctor's Staff providing information

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Signature of Doctor or Doctor's Staff providing information
(If phone contact, broker staff filling out this form)

_____ Date_____

Local Transportation Broker

Name _____

Address _____

_____

Phone # _____